Division of Health Care Facilities FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING TN3401 NAME OF PROVIDER OR SUPPLIER 11/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE HANCOCK MANOR NURSING HOME **1423 MAIN STREET** SNEEDVILLE, TN 37869 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 002 1200-8-6 No Deficiencies N 002 During the Life Safety portion of the survey, there were no deficiencies cited from 1200-8-6, Standards for Nursing Homes. Division of Health Care Facilities TITLE (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM 6899 701721 If continuation sheet 1 of 1

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